Vermont State Health Plan
2005

Part 5: Focus Areas - B

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Long-Term Care

Outcome desired: Vermonters who need long-term care and support will receive services that reflect their personal values and preferences in the least restrictive environment possible.

Action needed:

- Develop and use informed decision-making processes to assist people make long-term care decisions that best support their needs, values and preferences.
- Identify and fund strategies that lead to a well-trained, stable workforce in home and community settings.
- Assure that communities have adequate support services in place for family caregivers, including access to adult day centers, respite and support groups.

Background:
The term "long-term care" is used to describe the care and support that older people and people with disabilities need in order to perform their everyday activities, whether they are residents of a nursing facility or living in home or community-based settings. This support may include hands-on assistance with eating, bathing, using the toilet, dressing, and transferring from bed to chair, as well as assistance with tasks such as meal preparation, household chores and medication management. It also may include emotional support and other assistance in increasing independence and self-sufficiency through supported employment and volunteer activities.

People with Developmental Disabilities

People with developmental disabilities include those with mental retardation (IQ 70 or below), or pervasive developmental disorder, and substantial deficits in adaptive behavior. An estimated 11,500 Vermonters have developmental disabilities. An estimated 110 Vermont children are born each year with developmental disabilities adding approximately 100 per year, net of those who die or leave services. The growing number of individuals diagnosed with Autism Spectrum Disorders is also increasing the demand for services. Work has just begun to identify the number of people potentially in need of these services.

Generally, people with developmental disabilities require life long services and support including:

- Individualized community support services to promote skill development and promote positive growth
- Employment assistance to help people get & keep jobs
- Home based services to help people in and around their home; hourly or 24 hours/day
- Respite in the form of hourly or daily short term relief for caregivers
- Transportation

- Clinical interventions including assessment, therapeutic, medication or medical supports
- Crisis services for psychological, emotional, behavioral crisis
- Service planning and coordination to assist individuals and their families in developing, choosing, accessing and monitoring services

Eligibility for services in Vermont requires that a person meet this definition as well as meeting the funding priorities contained in the State System of Care Plan. In FY 2004, the Department of Aging and Independent Living (DAIL), Division of Disability and Aging Services provided public funded supports to 3,024 Vermonters, representing 28 percent of all people with developmental disabilities. One-third of those served were under the age of 22.

Among those who do not, are those who are able to function well in their communities without additional support, as well as a number who do not meet one of the funding priorities and/or are unaware of the benefits for which they could be eligible. Many individuals with developmental disabilities live at home with their parents and receive minimal services. However, more than 22 percent of those parents are aged 60 or older, and when they are no longer able to provide the needed supports, pressure to serve people with full, 24-hour-a-day; seven-days-a-week residential services will increase. [1]

Support services for the developmentally disabled population are provided through DAIL contracts with community mental health or other specialized service agencies.
Children with developmental disabilities also receive services from the Department of Health, Programs for Children with Special Health Needs and from special education programs in the schools.

Older Vermonters and Other Adults with Physical Disabilities

In the 2000 census 77,510 (13%) of Vermonters were over age 65; by 2020, there are expected to be 138,541 Vermonters (21% of the population) over age 65 (See Appendix F). Collectively, the older population has experienced, and continues to experience, improved health and longevity.[2] DAIL predicts a decline in the disability rate of almost 1 percent annually for Vermonters aged 65 and older during the period 2003 - 2008. At the same time, the prevalence of physical disability for the younger population is projected to climb at a rate of 3.1 percent annually until 2008, when it will slow to 2.6 percent.[3] These rate changes are due largely to technological and medical advances that make it possible for infants born with disabilities to live longer and for people who acquire a disability as a result of illness or injury to live longer.

In 1996, recognizing that many Vermonters living in nursing homes would prefer to live in less-expensive, non-institutional settings, and also recognizing that the State's long-term care expenditures were growing at an unsustainable rate, the Legislature directed state government to use its purchasing power to decrease the utilization of nursing homes and to develop more home

[1] Vermont Department of Developmental and Mental Health Services. *Developmental Services 2003 Annual Report.*
[2] VDH. *Healthy Vermonters 2010*
[3] Vermont Department of Aging and Independent Living. *Shaping the Future of Long Term Care & Independent Living 2003-201.* January 2004

and community-based services. As a result, Vermont has seen a marked shift in its long-term care system toward greater use of home and community-based care.

Since 1996, funding for the Medicaid home and community-based waivers for the aged and physically disabled increased more than four-fold and the number of people served has increased by 65 percent.

Savings from the decline in nursing facility utilization have been used to expand home and community-based services and programs, including residential alternatives. Since home and community-based services tend to be less expensive than institutional care, Vermont has been able to increase the number of people served and the variety and scope of available services.

Home and community-based services for older Vermonters and other adults with physical disabilities are provided by many non-profit and for-profit organizations, as well as by family and friends. The long-term care and support system consists of:

- Fourteen adult day centers (with 17 sites)
- Twelve Medicare-certified home health agencies
- Five area agencies on aging
- Private nursing services and private personal care agencies
- 110 residential care homes
- More than 1000 direct care providers who are employed directly by elders and persons with disabilities

Home-care Workforce

Many Vermonters provide health care and support for adult family members and friends who, because of disabling illnesses or conditions, have limited ability to perform activities such as bathing, managing their medications and preparing meals. While informal and family caregivers provide most care to older people and other adults with disabilities, family care giving exacts a heavy emotional, physical and financial toll on caregivers, and depression is a common occupational hazard among people who are primary caregivers to patients with dementia.[4]

A significant portion of home based care is provided by paid workers. Many direct-service home care providers work under challenging conditions, earn low wages, work in conditions of social and professional isolation, and receive few benefits, all of which contribute to a high turnover rate and make life more difficult for consumers. This turnover also results in increased recruitment and training costs for providers, which eventually feeds into the rising cost of health care.

When a family's care giving capacity, if any, has been exhausted and direct care home-based services are not readily available, the alternative of institutional care in nursing homes results in significant, needless expense for residents who would prefer to be at home. Preventable physician and emergency department visits and hospital admissions also increase. Collectively,

[4] AHRQ Research Activities, No. 283, March 2004

these medically unnecessary social admissions to health care institutions also create unnecessary demands for extra staff, beds and infrastructure. Greater support for respite services could extend the capacity of family care giving at relatively little expense, thus lessening the unnecessary utilization of institutional services.

Greater investment in a well-trained, stable, in-home workforce would result in similarly significant savings, and as the average population increases in age, the need for this workforce will increase. Many states are designing and financing diverse strategies to support both informal family caregivers and paid direct-service home care workers, rebalancing their long-term care systems away from institutional care and toward strengthening integrated home and community-based services. Vermont has several such initiatives underway, and these should be supported and expanded.

Maternal and Child Health

Outcome Desired: The special needs of infants, children, and women of child-bearing age are fully integrated into the model for lifelong prevention and care.

Action needed:

- Improve the incidence of healthy birth outcomes through early and adequate prenatal care; promote and support breastfeeding to provide optimal nutrition for all infants.
- Increase the quality of and access to health care for women in state custody; increase the access to and utilization of preventive and follow-up health care services for children in state custody.
- Ensure continuous monitoring and evaluation of the health care needs and health outcomes of pregnant women, infants, children and their families. This includes:
- Support and encourage child health providers to make available Medical and Dental Home services for all children and to provide the extended services which are needed for children with special health needs (CSHN), through policies, reimbursement practices and other means.
- Enhance access of CSHN and their families to allied health professionals whose specialized expertise improves management of problems identified by the medical home provider (e.g. dietitians, mental health providers, and neurodevelopmental interventionists). Payment for necessary services identified by the medical home provider should be allowed.

Background:
Caring for our society's women, infants, children and their families during their formative and potentially vulnerable years has been a public health focus and a priority for health care for generations. The prenatal, childhood and young adult stages of life offer the greatest opportunity for preservation of life-long health and prevention of disease and injury. It is critical that, as the general population ages and the needs of adults with chronic conditions increases, this focus not be lost.

By many measures, Vermont is viewed as an excellent place for families to live and to thrive. The infant average mortality rate for the period 2001 -2003 was 4.9 per 1,000 live births, which is nearing the Healthy Vermonters 2010 goal of 4.5. Vermont's annual rate of reported child abuse and neglect aged birth to 18 years is 240 incidents per 10,000 population, the sixth lowest rate in the nation. In 2003, 90.6 percent of Vermont's pregnant women received prenatal care in the first trimester of pregnancy, versus a national average of 84 percent. Vermont has one of the lowest national teen pregnancy rates at 19 per thousand (ages 15-17 in the year 2000).

In 2003, 89.5 percent of Vermont children were considered fully vaccinated, the national goal being 90 percent. Through the Dr. Dynasaur (Medicaid) program, Vermont provides government health insurance coverage intended to be sufficient to ensure financial access to health care for

all children, pregnant women and new mothers. Vermont is also one of six states to have met the breastfeeding goals set forth in the national Healthy People 2010.

However, troubling health indicators remain. Smoking is the major preventable contributor to low birth weight, yet 18.3 percent of Vermont's pregnant women smoke, compared to 11 percent nationally. Statewide data on alcohol use by pregnant women and its resultant effects on infants are sparse, but many indicators point to this as being an issue needing a system-wide response. In a recent state survey, more than a quarter of Vermont students reported using marijuana in the previous 30-day period and nearly that many reported binge drinking (5 or more drinks on the same occasion).[5] Other recent data are beginning to establish the prevalence of intimate partner violence and of sexual violence among teens. Breastfeeding rates among low-income women are well below those for the general population.

Prenatal Care and Birth Outcomes

Evidence-based strategies to achieve optimal birth outcomes are, with some exceptions, well known. These include healthy behaviors to be adopted before pregnancy, planned pregnancies, early and adequate prenatal care, and, for high risk pregnancies, comprehensive follow-up and, when appropriate, transfer to a center with the expertise to care for critically ill newborns.

Birth outcomes are described by such measures as infant mortality, prematurity rates, and congenital anomalies. Many social conditions, environmental factors and personal behaviors can influence the outcomes of a pregnancy. Pregnancy can present an optimal time to support a woman and her family to learn about and adopt healthy habits and to seek needed services such as counseling and dental care. Adopting a healthy diet, achieving optimal weight gain, or stopping smoking will not be any easier during pregnancy, but interest in trying, and the potential to succeed if adequately supported, may be higher during this major life event. Other influences, including access to affordable and quality health care, safe housing, and coordinated community services, are also important in favorably influencing birth outcomes.

As is the case with chronic disease, there is a large body of evidence demonstrating the association of favorable outcomes with high-quality prenatal and delivery services and with widespread acceptance of these standards. It is critical that priority be given to: a) early, comprehensive prenatal care; b) timely transfer of high risk pregnant women and fragile newborn infants to regional neonatal/perinatal centers; c) a decrease in the prevalence of low birth weight, through smoking cessation services, management of multiple pregnancies, and appropriate weight gain and postpartum weight loss. In addition, access to contraceptive methods and reproductive services, which help achieve optimal birth spacing and a reduction in unintended pregnancies, counseling on use of folate, avoidance of alcohol, drugs and tobacco and other pre-pregnancy interventions are essential services that should be incorporated into practice, and supported by health care sector polices and reimbursement practices.

[5] VDH. *Youth Risk Behavior Survey*. 2003

Family and Child Health

Families are the most important factor in child health. The health behaviors that are modeled in the home, the values about health and health care that shape attitudes about health and the capacity of family members to nurture and promote positive health form the foundation for life. All other components of the health system should recognize and accommodate this fact.

Income, education, teen pregnancy and single parenting are all important determinants of a family's health values and shape their health behaviors. When low income forces a family to focus on the basics, it becomes difficult, and sometimes impossible, to focus on long-term health outcomes; access to food, any food, is more important than its fat or nutrient content, and the short-term stress reduction of cigarettes may be more important than the long-term consequences of clean air or lung cancer.

A medical home is not a building, house, or hospital, but rather an approach to providing consistent, comprehensive health care services in a high-quality and cost-effective manner. Children and their families who have a medical home receive the care that they need from a pediatrician or physician whom they know and trust. The pediatric health care professionals and parents act as partners in a medical home to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential. Services include information, skills development and incentives for families to adopt risk-factor reduction and lifestyle patterns which encourage positive nutrition and exercise habits, avoidance of sexually transmitted diseases, drugs and obesity.

Building Bright Futures: Vermont's Alliance for Children is a state-private partnership to foster collaboration among health, education, and social services to develop a coordinated, early childhood system of care for enhancing school readiness. In its work, this public-private partnership continuously monitors and evaluates the health care needs and health outcomes of pregnant women and infants, children and their families.

Community supports for families in stress, be it from poverty, ill health, separation or other factors, are essential to ensuring that children grow into healthy adults with better health habits and a recognition of their role as their personal health care provider.

Many of the special health problems of children are noted throughout this plan. These include the growing rate of child obesity, need for mentoring services in the community, injury prevention, mental health, substance abuse prevention and treatment and other issues. Like adults, children need a health system that integrates health care with public health and the community, focuses on prevention, ensures access to services and is characterized by high quality, accountable services. Unlike adults, children cannot advocate for these services themselves, so it becomes incumbent on their families and schools, their health providers and other adults to assume this role for them.

School Health

Public school education has changed significantly over the past several decades, and with these changes has come the recognition that schools are in an optimal position to play a strategic role in promoting and protecting the health of children and youth.

The federal Centers for Disease Control and Prevention (CDC) have identified six preventable risk behaviors that are often established in childhood. [6] They include:

- tobacco use
- unhealthy eating
- inadequate physical activity
- alcohol and other drug use
- sexual behaviors that result in HIV infection, other sexually transmitted diseases or unintended pregnancies
- behaviors that result in violence and unintentional injuries, including those sustained in motor vehicle crashes

With the support of families, schools and communities working together, the coordinated approach to school health improves students' health and their capacity to learn. This approach includes promoting a health education curriculum that is designed to motivate and assist students to maintain and improve their health, to prevent disease, and to reduce health-related risk behaviors by demonstrating increasingly sophisticated health-related knowledge, skills and practices.

In 1978, 1983, and again in 1988 (amendment to 1978 law), the Vermont Legislature passed laws addressing comprehensive health education in primary and secondary schools.[7] Rules promulgated by the Vermont Department of Education (DOE) in 1999 support the development of standards-based health education and assessment. According to the DOE standards, all students shall be taught the essential knowledge and skills they need to become health literate, to make health-enhancing choices, and to avoid behaviors that can damage their health and wellbeing.

Due to increasing financial demands on school budgets, however, both health services and health education are at increased risk of being cut from school budgets. Good laws, rules and guidelines for comprehensive health education are in place, but resources are short and compliance is far from universal.

In addition to separate health education courses taught by qualified health educators, health instruction should be integrated into physical education, family, consumer science and other content areas. Science and math courses, for example, should include the practical application of

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[6] CDC. Healthy Youth! Health Topics. Six Critical Health Behaviors. Hwww.cdc.gov/HealthyYouth/healthtopics/H

[7] Comprehensive Health Education Law 16 V.S.A. § 131; and,
Alcohol and Drug Prevention Education Programs 16 V.S.A. § 909.

the analytical skills necessary to assess health risks, the probability and mechanics of exposure to infection, and the arithmetical basis of insurance claims and premiums. Students must have the opportunity to apply their critical thinking skills to the analyses of such things as magazine ads for tobacco and alcohol and television promotions for brand-name pharmaceuticals and nutritionally deficient foods.

The comprehensive, coordinated school health approach reinforces students' adoption of health-enhancing behaviors by encouraging school staff to model healthy life styles. All school faculty and staff become responsible in this system-wide approach for ensuring that the school environment and school climate promote consistent health messages. Vermont schools should model health behaviors by ensuring the nutritional quality of food served or vended, by providing daily opportunities for physical education, and by enforcing appropriate policies about such things as substance abuse and conflict resolution.

Such coordination, however, requires skilled staff time sufficient to coordinate faculty and staff around health issues. It also requires some common sense regarding issues such as freedom of choice at the school candy machine. No one would think of excusing the sale of guns or tobacco in our schools under the guise of allowing students to learn about mature decision making. There should be no school-sanctioned offering of unhealthy foods and beverages on school premises or at school events unless it is for the express purpose of demonstrating that what is taught in the classroom doesn't really matter.

In economic terms, such a high-quality, well-coordinated school health system is amply justified on the basis of short-term benefits for student learning and long-term benefits for public health.

Children with Special Health Needs [CSHN]

Children with special health care needs are those who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions that require health and related services of a type or amount beyond that required of children generally. It is estimated that about 15.5 percent of Vermont children have a special health care need.[8]

Families with CSHN experience much higher expenditures for health care, including out-of-pocket expenditures, than other children. In a 2000 study, compared with other children, CSHN had three times higher health care expenditures ($2099 vs. $628). While only 15.6 percent of the children in the study had special health needs, they accounted for 33.6 percent of total health care costs, including dental. Insurance coverage provided families with the best protection against inpatient hospital care expenses and left them most exposed to dental care expenses.[9]

"Provide and promote family-centered, community-based, coordinated, comprehensive care for CSHN and facilitate the development of community-based systems of service for such children and their families" is the stated mission of the Vermont Programs for Children with Special Health Needs at the Department of Health. The needs of this very special population must be

[8] Maternal and Child Health Bureau . *Telephone survey of families of CSHN in all 50 states*, 2003.
[9] Newacheck PW, Kim SE. A national profile of health care utilization and expenditures for children with special health care needs. *Arch Pediatr Adolesc Med*. 2005 Jan;159(1):10-17.

addressed in all aspects of implementation of the Vermont State Health Plan. Specific priorities include:

- Ensure that all newborns are screened to identify and treat serious conditions that benefit by pre-symptomatic treatment. This requires routine monitoring of screening rates and quality, training for hospital and community-based screeners; provision of timely clinical follow-up to confirm cases, early entry into effective treatment, and regular reports to providers and the public;.
- Ensure adequate insurance to pay for services. This includes assisting eligible families to apply for Dr. Dynasaur and/or other services, assistance to Medicaid policy-makers to assure that CSHN do not lose/drop Medicaid coverage; inclusion of parents in advising and decision making processes for Medicaid; and advocacy with health care payers on behalf of CSHN for coverage of medically necessary services and for more timely decisions about coverage
- Ensure CSHN's receipt of, not just access to, coordinated, ongoing, comprehensive care within a primary care medical home. This requires the training of primary care providers at the student, residency and practice levels in the care of CSHN; developing and implementing improved CSHN program methods for coordinating and facilitating effective communication among specialty care, primary care, community services, and families; and participation in interagency planning to encourage medical home improvement activities.
- Ensure that services for CSHN are family-centered, so that families partner at all levels and are satisfied with services. Strengthen the voice of families in system review and design, including family participation in needs assessment, data review and service planning.
- Ensure services to support youth transitioning to the adult system of care. This includes encouragement for family practitioners and internists to provide medical homes for young adults with special health needs; engaging specialists in adult fields to identify what they need to provide comprehensive services to young adults with historically "childhood" chronic conditions; and encouraging medical home primary care providers to participate in interagency transition/life care planning for older adolescents with special health care needs.

Mental Health

Desired outcome: All Vermonters with mental health needs thrive in healthy communities.

Action needed:

- Improve integration of mental health services into primary care, focusing on prevention, screening, early intervention and referral when indicated.
- Fully integrate the treatment of severe and persistent mental illness with the Vermont Blueprint for Health. This integration must include:
  - Informed decision-making systems for individuals and families that explain choices about programs and providers, so that they may fully participate in planning and evaluating treatment and support services in light of their own preferences.
  - Enhanced self-management and peer support services as a further step toward a more recovery-oriented system of mental health care in Vermont.
  - Commitment to and further development of community-based care, supporting the most integrated community settings and least restrictive alternatives for care through a full range of community-based treatment and support options.
- Develop community outreach programs to identify individuals at high risk for mental illness or associated problems and to assist them in obtaining needed services from the most appropriate community resource.
- Review the laws, regulations and practices regarding medical treatment for individuals who may lack capacity to make an informed decision regarding their treatment and recommend change where indicated.
- Develop community-based suicide prevention services based on the National Strategy for Suicide Prevention.

Background:

> "*Mental health* is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. From early childhood until death, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem.
>
> "*Mental illness* is the term that refers collectively to diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood or behavior (or some combination thereof) associated with distress and/or impaired functioning."
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> Mental Health: A Report of the Surgeon General [10]

[10] U.S. Department of Health and Human Services (DHHS). *Mental Health: A Report of the Surgeon General* (Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services,

Mental illness is the product of the interaction of biological, psychological and socio-cultural factors. Causes may include predispositions within one's genetic makeup, environmental stressors that one experiences, and variations in brain chemistry. Mental illness typically has non-medical dimensions that may be described as spiritual, emotional, psychological, social or economic, and the symptoms may be located in relationships and other social contexts, as well as being located within the individual.

As is the case with physical health, mental health and mental illness occupy opposite ends of a continuum, and individuals are more or less healthy or ill at different times. Mental health is essential to overall health;[11] it governs and is governed by other aspects of health and plays an important role in the rate at which patients recover from injuries, operations and physical ailments. Mental illnesses may occur with other conditions, either as a contributing cause or as an effect of conditions such as substance abuse, diabetes, heart disease and physical handicaps.

Impact of Mental Illness

The overall impact of mental health problems and illness is significant and frequently underestimated. Mental illness ranks first among illnesses that cause disability in this country,[12] and it is devastatingly expensive. Nationally, it accounts for $71 billion annually in direct costs, measured by expenditures on treatments for mental illnesses, and an additional $79 billion in indirect costs, measured by the loss of productivity because of illness, premature death, or incarceration.[13]

It is likely that a significant but unmeasured portion of the population in need of care fails to receive it. At the national level, less than one-third of adults with a diagnosable mental disorder receive mental health services in a given year, and the proportion is even smaller for children.[14]

Based on national studies, it is estimated that in Vermont during any given year as many as one in four adults and one in five children will have a diagnosable mental health condition or mental illness that has a negative effect on well-being and/or ability to function in daily life.[15] These conditions include severe forms of illness such as schizophrenia and major depression; moderately severe conditions such as depression, generalized anxiety, panic, obsessive-compulsive disorder and post-traumatic stress; and less severe conditions such as grief reaction and adjustment disorders. It is estimated that more than 28 percent of Vermonters with mental health disorders also have substance abuse disorders. [16]

National Institutes of Health, National Institute of Mental Health; 1999. page 4-5. Hwww.surgeongeneral.gov/library/mentalhealth/home.htmlH

[11]The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville MD: 2003, pp. 17, 19-26.

[12]World Health Organization. (2001) *The World Health Report 2001—Mental Health: New Understanding, New Hope*. Geneva: World Health Organization, cited in *Achieving the Promise*, p. 3.

[13] *The World Health Report 2001*, p. 3.

[14] DHHS. *Mental Health: A Report.* p. 65.

[15] DHHS. *Mental Health: A Report.* pp. 123-24 and 227-28.

[16]Agency of Human Services. *Co-occurring Substance Abuse and Mental Disorders: AHS Plan for Future Directions.* 2004.

The scope of services for mental health is no different than that of other health services and extends from prevention, through screening, diagnosis, treatment and aftercare. While the treatment systems for mental illness and other illnesses have evolved separately, there is significant overlap with prevention and primary care.

Prevention

Numerous environmental risk factors for experiencing mental health problems have been identified. They include exposure to violence, abuse, neglect, substance abuse, homelessness, lead poisoning, economic hardship, accidents and injuries, loss of a loved one through death, divorce, or broken relationships, and severe stress or rejection because of discrimination based on race, sexual orientation, religion, or poverty. The more risk factors a child, adolescent, or adult encounters, the greater the risk of mental, emotional, or behavioral problems and the higher the importance of counterbalancing these risks to prevent or limit the problems that could develop.

Helping youth to develop the understanding and master the skills needed to lead healthy lives within their home, school, and community is the basis of prevention and early intervention for nurturing the mental health of young children and adolescents. Internal and external factors that protect children and give them the resiliency needed to overcome difficult circumstances have been identified and are listed in Appendix D.

Prevention of mental problems in youth requires that families and communities work together to so that youth are supported and empowered, know what is expected of them and have opportunity to participate in creative, fulfilling endeavors. Prevention also requires nurturing youth in their areas of learning, values development, social competency and positive self-identity. For youth at risk, the earlier that intervention occurs to reinforce the protective factors in the child, family and community, the better the prognosis.[17] See Chapter: Prevention As a Priority.

Suicide prevention

Suicide, the ninth leading cause of death in Vermont, is a serious public health problem among all Vermonters, young and old. There were 1,018 suicides in Vermont in the period 1990-2002, or an average of 85 per year, 82 percent of them among men. The greatest number of suicides occurs among men ages 35 to 44, while the highest rate of suicide is among men 85 years of age or older (Figure 14).[18] The rate of suicide among male teens has increased threefold nationally since the 1960s and is another cause for concern.[19]

Figure 14
Suicide in Vermont Men 1990-2002

Age Group	Total Number	Percent of all Suicides	Rate per 100,000 population
10-14	7	0.8	2.5
15-19	46	5.4	15.6
20-24	83	9.9	30.7
25-34	154	12.8	28.8
35-44	159	13.3	25.4
45-54	137	11.4	26.9
55-64	82	6.8	24.5
65-74	67	5.6	28.9
75-84	77	6.5	62.3
84+	28	2.3	89.6

[17] DHHS. *Mental Health: A Report.* pp. 132-33.
[18] Vermont Department of Health. Division of Health Surveillance. *Unpublished.* 2004.

In 2002, there were 272 emergency department visits associated with suicide attempts in Vermont, and 91 fatalities (76 male and 15 female). Females in Vermont are twice as likely as males to attempt suicide, but males are nearly five times as likely to die in the attempt. Firearms are the most common method for suicide fatalities, followed by poisoning and suffocation. Vermont has the highest firearm-related suicide death rate of the six New England states.

Over 90 percent of children and adolescents who commit suicide have a mental disorder, such as depression, possibly complicated by co-occurring substance abuse.[20] Thus it is important that our response to this problem not only involve targeted suicide-prevention efforts, but also address behavioral and emotional problems. Prevention programs that have documented success include early identification of people at imminent risk; assessment of individual risk and protective factors (individual, family, community and environment); and early identification and intervention for depression and substance abuse. Identifying individuals at risk for suicide requires a community response, in addition to better training for health professionals and increased awareness on the part of police and correctional personnel, clergy, teachers and school staff, and other community members who interact with large numbers of people. Suicidal behavior can be reduced and problems such as aggression, substance abuse, poor school performance and absence, depression, and anxiety can be ameliorated as well.[21]

Primary Care Services

The role of the primary health care provider includes screening for a wide range of health problems, including mental problems, and acting to correct, control or reduce the impact of those problems. Full integration of mental health services into primary care requires that providers have reliable screening tools to assess mental health problems and that evidence-based standards be used to determine the level of care required and to provide that care or refer appropriately. Training and information systems must be in place to support the provider in this role.

Assessment and diagnosis of late-life mental disorders are especially challenging by virtue of several distinctive characteristics of older adults. First, the clinical presentation of older adults with mental disorders may be different from that of other adults, making detection of treatable illness more difficult. Primary care providers carry much of the burden for diagnosis of mental disorders in older adults; however the rates at which they recognize and properly identify disorders often are low. Cognitive decline, both normal and pathological, can be a barrier to effective identification and assessment of mental illness in late life.

The vast majority of people with mental problems, particularly those with short-term or less severe problems, are cared for exclusively by their primary care provider. Many are likely to go without care altogether. The Vermont Blueprint for Health, with its collaborative model of care, reliance on evidence-based standards and use of clinical information systems to monitor progress

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[19]Institute of Medicine, *Reducing Suicide: A National Imperative.* Washington (DC): National Academies Press; 2002.
[20] DHHS. *Mental Health: A Report.,* pp. 154-55.
[21] National Strategy for Suicide Prevention, U.S. Department of Health and Human Services. Hwww.mentalhealth.samhsa.gov/suicideprevention/H

and improve systems for the delivery of care, offers an opportunity to improve the quality of mental health services for patients in the primary care setting.

Treatment Services

Mental Health treatment services are those that are delivered by providers specifically trained to treat the complex needs of people with mental illness. A combination of private and public entities makes up the Vermont care system for mental illness and includes:

- Vermont State Hospital
- 10 community mental health agencies designated by the Commissioner of Health as the local lead agency to provide comprehensive services to adults with severe mental illness and children and youth with severe emotional disturbances
- 5 hospitals with psychiatric inpatient services that have been designated by the Commissioner of Health to provide treatment to individuals involuntarily committed to the Commissioner's care and custody.
- Psychiatrists, psychologists, social workers and other providers in private practice.

Use of the Chronic Care Model (CCM) as a tool for improving care for individuals with more severe exacerbations of mental illness has been piloted by the Office of Vermont Health Access, community mental health agencies and primary care providers over the past several years with promising results. The Vermont Medical Home Project has addressed the care of individuals with severe mental health and other disabilities. The Vermont Community Depression Project has addressed improved coordination between the community mental health agencies and primary care providers. See Chapter: Chronic Conditions.

Expansion of these projects to other settings and diagnoses and increasing participation by primary care providers is now needed. The Vermont Blueprint for Health, which is based on the CCM, provides an essential organizing structure for managing the care of people with long-term, complicated health problems. The goal of enhancing clinical and functional outcomes is predicated on planned, proactive care by the provider and an activated, informed consumer who work together to set and accomplish treatment goals.

Adult Services

Two population groups are the primary recipients of specialty mental health services. The largest includes adults with emotional and behavioral problems that disrupt their lives and are sometimes temporarily disabling. Many of them have attempted suicide within the past year or are afraid that they will do so. Alcohol and drug abuse are common. They frequently have histories of psychological trauma, with lingering impairments to their ability to cope with everyday living. Common difficulties may include maintaining a household, managing money, getting around the community, and taking prescribed medications. Marital and family difficulties are strikingly common, and so is poverty. Vermont Adult Outpatient Programs served approximately 7,000 individuals and families in fiscal year 2004.

The second group includes adults with diagnoses of major mental illnesses such as schizophrenia, bipolar disorder, major depression, and serious disorder of thought or mood.

These individuals often have a long-term disability (as evidenced by social isolation or poor social functioning, a poor work history, or qualification for federal Supplemental Security Income) and are likely to have had a recent history of intensive and ongoing mental-health treatment (multiple psychiatric hospitalizations, for example, or six consecutive months of outpatient treatment). Vermont Community and Treatment Services (CRT) served 3200 adults in fiscal year 2004.

Current Vermont laws are inconsistent regarding medical treatment for individuals who may lack competence to make informed treatment decisions, and the criteria to determine competence. This situation merits review as it has implications for the right to due process, the right to appropriate treatment, and rights regarding advance directives for health care.

Child, Adolescent and Family Services.
Treating mental disorders in children and adolescents requires a complex analysis of development and of discrete disorders. Services for youth need to be organized around the concept of resiliency, with an emphasis on prevention and early intervention to strengthen protective factors and ameliorate risk factors. In defining child and adolescent mental health and mental disorders, it is critical to avoid thinking that children or even adolescents are "little adults." Even more than adults, children are impacted by their social environment (family, peers, physical and cultural surroundings). Equally profound is the ongoing development of the body, and especially the brain.

Human development is marked by periods of transition and reorganization; change, especially rapid change, is usually stressful. Nevertheless, at some level of intensity, symptoms and behaviors can cause great distress for the child, the family, and others. At these points, it is helpful to consider serious deviations from expected cognitive, social, and emotional development as mental disorders. Given the process of development, it is not surprising that these disorders in some youth may wax and wane. Some youth improve as development continues, perhaps as a result of healthy influences. Other youth, some formerly only "at risk," may develop full-blown forms of disorder as severe and devastating as the analogous conditions that affect adults. And because of the growth potential in each child and adolescent, it is especially important that supports and treatment services be available in the home, school, and community to maximize their development.

Vermont's mental-health system of care offers five types of core capacity services available regionally through designated agencies:

- Immediate response: intensive, and time-limited (usually 2-3 days) interventions for families in crisis.
- Outreach treatment: clinical services available in the home, school, and general community settings.
- Clinic-based treatment: assessment; group, individual, and family therapies; service planning and coordination; and medication services.
- Support: to help reduce family stress and provide parents and caregivers with additional guidance, support and skills to nurture a difficult-to-care-for child.

- Prevention, screening, referral, and community consultation: community agreements to promote psychological health and resilience for families and youth.

These five core capacity services meet the needs of the majority of Vermont's youth. For a small percentage of youth, more intensive services are needed. Vermont is a recognized national leader in the development of community-based intensive services within a system of care. These services include intensive services "wrapped around" a child in his/her home, school, and community. A wraparound plan is the generic term for an intensive, individualized program of care, usually including support and supervision 24 hours a day. Each program is created for one person, based on that person's unique needs and strengths. Children's Services in Vermont served more than ten thousand children and adolescents and their families in Fiscal Year 2004.

Emergency Services

Vermont's public mental-health system offers Emergency Services for anyone experiencing a mental-health crisis. Emergency Services are available from designated agencies all around the state twenty-four hours a day, seven days a week. In addition, communities or organizations trying to cope with natural disasters or with an unusual, traumatic event, such as a suicide that shakes a school community, also rely on Emergency Services, not only for collective help, but also for help to individuals in managing their reactions to such traumatic events. Vermont's Emergency Services programs provided, at a minimum, telephone support, assessment and referral to approximately seven thousand people of all ages in Fiscal Year 2004. About 25 percent of the people who receive Emergency Services have no insurance, and another 25 percent have private insurance that does not always pay for services for a mental-health crisis. More than 75 percent of Emergency Services costs are paid by public funds.

Self-Care and Community Services

Increased participation by consumers and families in their own treatment plans, in the administration of services, and in the development of policy has precipitated a change in culture of mental health services that now emphasizes recovery, resilience, and independence. These advances and others offer tremendous opportunities for reform.

In addition to those who receive care and counseling from licensed, certified or registered Vermont mental health specialists in the public and private sectors, many deal with their illnesses by seeking help from support groups, from clergy, and from other alternative sources or methods. Many others receive their treatment exclusively from primary care physicians.

The concept of recovery is gaining prominence in the field of adult mental health as an achievable goal for both individuals and systems.[22] Recovery has many definitions. For one expert, it means "a process of learning to approach each day's challenges, overcome our disabilities, learn skills, live independently and contribute to society."[23] For others, recovery may be "the ability to live a fulfilling and productive life despite a disability." Or it may imply

[22]*NASMHPD/NTAC* (National Association of State Mental Health Program Directors/National Technical Assistance Center) *e-Report on Recovery* Home Page, Hwww.nasmhpd.org/spec_e-report_fall04intro.cfmH *Achieving the* Promise, p. 4.
[23]Ruth Ralph, quoted by the *NASMHPD/NTAC e-Report*.

"the reduction or complete remission of symptoms. . . Having hope plays an integral role in an individual's recovery."[24] Stressing independence, peer support, and community-based services, the recovery concept originated among adults with mental illness, many of whom had been institutionalized and had found peer support to be an important component of their own recovery. They challenged the prevailing model of care, with its more modest goals of preparing individuals to work in closed workshops and live under supervision, an approach that carried with it the implication of life long illness, increasing disability, and ongoing need for treatment, frequently in an institution.

Recovery also reflects attitudes and principles of design for the mental health care delivery system. It complements, but does not replace, other mental-health supports and services that help people live independently in their communities.

Quality of Care

For adults with severe mental illness, the Vermont Department of Health and community providers emphasize evidence-based practices, promising emerging practices, and values-based practices. Evidence-based practices are those for which consistent scientific evidence shows that they improve client outcomes. Vermont has implemented five evidence-based practices: Assertive Community Treatment, Family Psycho education, Illness Management and Recovery, Integrated Treatment for Dual Diagnoses of Mental Illness and Substance Abuse, and Supported Employment.

Promising emerging practices are those for which scientific evidence is accumulating and is appearing in the literature in the field. The public system has an additional duty to pursue implementation of promising emerging practices by identifying gaps in current services and practice approaches that fail to address the needs of clients and their families, searching for practices that show promise in addressing those needs, and then learning about the practices and implementing them. Dialectical Behavioral Therapy for persons with borderline personality disorders is very close to meeting the evidence-based standard and has been adopted in nine of Vermont's 10 mental-health catchment areas. The Health Department is exploring practices that are particularly helpful to people who have experienced trauma in their lives.

Values-based practices are practices that promote recovery, empowerment, and community integration; they lack rigorous formal scientific evidence established through experimental trials, and yet the evidence we have and the values we share tell us that they work for clients. These practices are often peer-based or peer-operated. Examples of values-based practices in Vermont are Recovery Education, Family-to-Family Education, and Family-Provider Education.

Note: The 2004 Legislature called for studies of several aspects of public mental health care. Concurrent with the development of the Vermont State Health Plan, planning was initiated for the replacement or distribution of the functions and services provided by the Vermont State Hospital, a system evaluation was made of the community mental health centers, and a comprehensive mental health services plan was developed by the Department of Corrections. These plans are incorporated here by reference (See Appendix B).

[24] *NASMHPD/NTAC e-Report on Recovery Achieving the Promise*, p. 5.

Oral Health

Outcome desired: Vermonters have access to oral health services that are fully integrated with health care, public health and community services.

Action needed:

- Accept the Vermont Oral Health Plan and ensure implementation of the recommended strategies by providers, individuals and communities. See Appendix B.
- Recognize that the Oral Health Plan is a significant step in what must be a concerted and ongoing effort to forestall a decline in access to dental services.
- Craft new approaches and solutions to the prevention of oral disease and problems of access to dental care through a commitment by consumers and medical, dental and public health providers to work together.

Background:
The fragility of the dental health system in Vermont is being recognized within the dental profession itself, within the health care sector and among policy makers in public health. According to the 2003 Vermont Survey of Dentists, conducted biannually by the Department of Health, the number of dentists increased by 20 between 1999 and 2003; however, the number of full-time equivalent dentists decreased from 290 to 281 during that same time. This is reflective of the aging of the Vermont dental workforce. More than one-third of the 367 dentists planned to retire within 10 years. The 2003 dentist survey reveals a wide ranging dentist-population ratio across the state, from 10 per 100,000 population to 47 per 100,000.

Exacerbating the problem is that Vermont has no in-state dental school and, as a percent of the population, sends fewer of its young people to dental school than any other state. Between 1986 and 1993, the number of dental schools in the United States decreased by six. Dental school graduates declined by approximately 37 percent from the early 1980s to 1990, but rebounded between 1993 and 2002, with a 15 percent increase from 3,778 to 4,349. In 2002, the number of graduates remained unchanged.[25]

Most Vermont dental practices follow the model that primary care once followed: independent practices consisting of one or two individual providers who own the "business." Dental care has traditionally been a separate service, with care and treatment of dental conditions being delivered separately from other aspects of health care. However, there is an increasing understanding among medical and dental providers that oral health is an integral part of personal health, affecting and being affected by a range of medical conditions.

The fragility of the dental system can be a challenge for people who use Medicaid, for those without means to pay for dental services, and for Vermonters in rural communities with an inadequate number of local dentists. Hospitals, health centers and the public school system have increasingly been called upon to address these gaps in service.

[25] Vermont Dental Society. 2005. *Unpublished.*

Vermont Oral Health Plan addresses four major areas:

- Public health infrastructure, to maintain an oral health surveillance system, to build partnerships and integration between the public and private sectors, to promote education, and to implement services that increase effectiveness, accessibility, and the quality of oral health services.
- Prevention and health promotion, to increase understanding of oral health as integral to overall health, to promote the establishment of dental home for each individual, and to promote and to provide for fluoridation, dental sealant use and the early detection of oral cancer.
- Workforce development, to enhance efforts to recruit dentists, to explore the use of dental and non-dental providers, to provide continuing education opportunities, and to provide for the systematic collection of dental workforce data.
- Financing and delivery systems, to promote collaboration among government financed dental clinics and private practice dentists, to develop an economic model to understand the impact of reimbursement on access, and to support a community-based and coordinated social support system to increase access.

The Vermont Oral Health Plan outlines important strategies that, if followed, will help to ease the problems of dental access over the next several years. A declining number of dentists serving an increasing population, including a higher proportion of older Vermonters with greater dental needs, warrants careful monitoring of the implementation and evaluation of the progress made under this plan (Figure 1). It is likely that Vermont will continue to face challenges in maintaining acceptable levels of access and may, in time, need to consider new models of care to meet the needs of the state's population. Models that have been tried in other jurisdictions include: collaborative dental centers, new workforce strategies to improve the efficiency and effectiveness of dental health professionals, integration of selected dental services into primary medical care, and additional incentives to enter dental practice.

The new system for health advocated in the Vermont State Health Plan calls for better integration of oral health services and provides the framework to accomplish this goal. In addition to changes in the health care sector and provider practice components, self management is critical, as are community services such as fluoridated water, promoting healthy food choices and creating a societal norm of good oral hygiene and appropriate use of dental services.

Substance Abuse

Outcome desired: Comprehensive, coordinated and effective drug and alcohol prevention and care services, offered in community-based settings will lead to reduced substance abuse and related problems.

Action needed:

- Integrate substance abuse services into primary care, with particular attention to pregnant women, focusing on prevention, screening, early intervention and referral when indicated.
- Develop, support and maintain primary prevention coalitions, programs and activities, including community coalitions now funded through the Department of Health's New Directions and Tobacco-free Community Grant programs.
- Develop and maintain a full continuum of geographically accessible treatment services including outpatient, inpatient and pharmacological treatment units. Expand the capacity for pharmacological treatment capacity for opioid addiction as follows:
  - Mobile or stationary methadone clinics
  - Office-based buprenorphine treatment.
- Increase aftercare and recovery services, including treatment modalities that include a strong focus on recovery management and relapse prevention.
- Continue to increase locally provided outpatient treatment and case management services that are coordinated and integrated with other community services (e.g. vocational counseling, criminal justice, and primary medical care) and that include safe and sober housing for people transitioning back from residential care and from incarceration.

Background:

Impact of Substance Abuse

Vermont has a serious substance abuse problem. Although most Vermonters have seen evidence of a heroin problem in the state only through media reports of deaths and increased crime, the problem of increasing prevalence and the associated damage have been evident in the state for some time. In 1995, a survey of adult Vermonters found that almost 10 percent of Vermonters needed substance abuse treatment, most for alcohol abuse. The same survey found that heavy alcohol users were five times as likely to be arrested as non drinkers or moderate drinkers. At that time, 63 percent of Vermonters felt that the severity of Vermont's drug problem was greater than it had been five years earlier.[26]

Research has shown that young people who drink alcohol before the age of 13 are almost five times more likely to develop a future diagnosis of alcohol dependence than those who begin

[26] Bray, R. M., Camlin, C. S., Kroutil, L. A., Rounds-Bryant, J. L., Bonito, AJ. & Apao. W. *Use of alcohol and illicit drugs and need for treatment among the Vermont household population: 1995*. August, 1997.

drinking at age 20 or later.[27] The 2003 Vermont Youth Risk Behavior Survey of students in grades 8 - 12 found that 25 percent reported having had their first drink before the age of 13.[28] The 2002 National Survey on Drug Use and Health (NSDUH) estimated that 11 percent of Vermonters aged 12 or older had used an illicit drug during the previous month. Among youth aged 12 - 17, the proportion was 17 percent; and among young adult Vermonters, aged 18 - 25, 30 percent reported past-month illicit drug use.[29]

The NSDUH found that 25 percent of Vermonters aged 12 or older reported binge drinking during, consumption of five or more drinks on the same occasion, in the past month. As with illicit drug use, this behavior is prevalent in adolescents and young adults. Almost 14 percent of children aged 12 - 17 and more than half young adults, aged 18 - 25, reported past-month binge drinking of alcohol. Among adults older than 25, more than 22 percent reported the same behavior.

With these indications of substance abuse prevalence, it is not surprising that many Vermonters are in need of treatment. The NSDUH found that close to 10 percent of Vermonters aged 12 and older needed treatment. As with the abuse indicators above, this need was higher among children aged 12 - 17 (more than 12 percent) and highest among adults aged 18 - 25 (over 23 percent). Based on the NSDUH estimates, more than 36,000 Vermonters who needed treatment for alcohol problems in 2002 did not receive any treatment, and more than 15,000 who needed treatment for drug problems did not get it.

Although many who need treatment are not treated, more people are being treated each year in the publicly funded treatment system. In 1998, about 5,500 people received such treatment. By 2003, the annual number had grown to 7,800, reflecting an increase of nearly 43 percent over five years; 6,570 people received outpatient treatment services, 779 received intensive outpatient services, and 1,650 received residential treatment. Several people received more than one type of service. Most adults seek treatment for alcohol-related problems, but most adolescents seek treatment due to the effects of marijuana.[30]

In FY1998, fewer than 200 people in Vermont were admitted for primary treatment of heroin/opioid problems. In FY2003, over 1,000 (about 13 percent of all patients) received treatment primarily for heroin/opioid problems.[31]

In 1998, there was no pharmacological treatment for opioid addiction available in the state. By 2004, 140 people were being treated at the Chittenden Center, a methadone clinic in Burlington. A mobile methadone program, expected to open in the spring of 2005, will serve approximately 150 people in the Northeast Kingdom. Many other Vermonters are receiving buprenorphine

[27] Grant, B. F., Dawson, D. A. National Institute on Alcohol Abuse and Alcoholism. Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse. 1997;* 103-110, 1997.
[28] VDH. *Youth Risk Behavior Survey*. 2003
[29] Wright, D. (2004). State Estimates of Substance Use from the 2002 National Survey on Drug Use and Health (DHHS Publication No. SMA 04–3907, NSDUH Series H-23). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.
[30] Vermont Department of Health , Division of Alcohol and Drug Abuse Programs. *Unpublished*.
[31] Vermont Department of Health , Division of Alcohol and Drug Abuse Programs. *Unpublished*.

from their physicians, and a medication assisted therapy program in central Vermont inducts and stabilizes patients for referral back to their physicians for this treatment. This program is providing needed assessments and supports to doctors in this important effort. Although much has been achieved over the past three years, more pharmacological capacity is needed.

Prevention and Community-Based Services

Vermont's Drug Education, Treatment, Enforcement & Rehabilitation (DETER) program, which is incorporated here as part of the Vermont State Health Plan, offers a comprehensive strategy that focuses on and finances a wide variety of prevention, treatment, and law enforcement efforts. It builds upon the base continuum of services for substance abuse issues: prevention, intervention, treatment and recovery services. It provides funding for student assistance professionals who provide prevention, education, screening and intervention for students in the school environment. One of the program's goals is to have a student assistance professional in every middle and high school in Vermont.

Strategies for substance abuse services include enhancing prevention and community-based services, increasing access to and integration of services, and ensuring quality and accountability. Substance abuse prevention efforts in Vermont recognize

- that there are multiple determinants of good health
- that environmental supports and consistent messages contribute to healthy and informed choices
- that multidisciplinary partnerships and coalitions are essential to improving health and that community prevention services and activities must be widely available and accessible in order to support healthy behaviors, to reduce risk factors and to increase the quality of life and health for Vermonters

Primary drug and alcohol prevention focuses on comprehensive planning at state and local levels to bring together community stakeholders, schools, and families to increase assets and decrease risk factors, especially among youth. Often linked with other health promotion activities, drug and alcohol prevention in the community should provide clear, consistent messages, combined with substance-free activities and hands-on skill building to assure that youth and parents lessen risks and develop healthier lives. At the personal level, the risk of alcohol dependence drops each year that drinking is postponed,[32] which means that preventing the early use of substances among youth is critically important to youth development and the avoidance of future problems.

Access to and Integration of Services

There are multiple physical, behavioral, social, economic, genetic and environmental influences that contribute to addiction. Many of these same influences can provide opportunities to prevent or limit progression of abusive alcohol and drug behaviors. Increasing healthy behaviors and reducing the damage of alcohol and drugs is a shared responsibility that must involve individuals, communities, health care providers, and public health and other social services.

[32] Grant, B. F., Dawson, D. A. National Institute on Alcohol Abuse and Alcoholism. Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey. *Journal of Substance Abuse*. 1997; 9:103-110.

Increased access to primary care physicians and widespread availability of community services that support early substance abuse screening and identification, aftercare and recovery maintenance, will help ensure that people can get intervention or treatment when they need it, and that the positive outcomes of these services are maintained over the long term. Coordinated, effective care can minimize or eliminate the health complications, injuries and social impacts of substance abuse, improving the quality and length of individual lives.

Most people who need treatment will not seek it. Many are unaware that they need it. The Vermont Department of Health's 1995 Vermont Household Telephone Survey found that about 95 percent of the Vermont adults who needed treatment but did not receive assistance indicated that they did not feel they needed treatment.

Research indicates that, as with many health conditions, drug and alcohol abuse and dependence is often progressive. Early detection and treatment can reduce the damage and need for more expensive and intensive treatment. Increasingly, health care and human service professionals are becoming more focused on screening and early intervention to help identify people at risk and to get them connected to the services they need. This is apparent in the development of drug courts in Vermont, the placing of student assistance professionals in the schools, and the implementation of screening practices in other areas where people access human services and health care.

Nationally, the screening for substance abuse problems in the traditional health care environment has not been widespread.[33] A 2000 national survey found that 94 percent of primary care physicians (excluding pediatricians) failed to include a substance abuse diagnosis when presented with early symptoms of abuse in an adult patient.[34] Only about 20 percent of physicians felt "very prepared" to identify alcoholism, less than 17 percent felt "very prepared" to identify illegal drug use, and only about 30 percent thought they were "very prepared" to spot prescription drug abuse. The average patient was abusing alcohol, pills and/or illegal drugs for 10 years before seeking treatment.

With respect to relapse rates and patient compliance, research has found that the effectiveness of treatment for alcohol and drug abuse is similar to the treatment effectiveness of other chronic diseases such as diabetes, hypertension, and asthma.[35]

Participation of the health care and community sectors is necessary to ensure that individuals access appropriate treatment and that their care is coordinated with the delivery of other services. Research also has shown the importance of access to and involvement in recovery maintenance activities in maintaining abstinence and improvements in other areas.[36]

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[33] The National Center on Addiction and Substance Abuse at Columbia University. *Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse*. Survey Research Laboratory, University of Illinois at Chicago, April, 2000.
[34] The National Center. *Missed Opportunity*.
[35] Physician Leadership on National Drug Policy, March 1998 Research Report. Hhttp://caas.caas.biomed.brown.edu/plndp/Newsroom/Press_Releases/PR2/pr2.htmlH
[36] Harrison, P. A., Asche, S. E. (2000, October). The challenges and benefits of chemical dependency treatment: Results from Minnesota's treatment outcomes monitoring system 1993-1999. St. Paul, MN: Minnesota Department

Accountability and Quality Assurance

Treating an individual holistically and understanding the role of substance abuse in diminishing health requires a coordinated and shared vision for care that recognizes the complexity of drug and alcohol abuse. It requires prevention, screening, and early identification and intervention to recognize and address problems as early as possible.

The substance abuse problem in Vermont is visible and pronounced. Most Vermonters are aware that drug and alcohol problems affect health, worksites, families and schools. What can be less apparent are the solutions. There is a strong body of research that demonstrates the effectiveness of treatment and its positive impacts on crime, health care utilization, and employment. There also is substantial research on what kinds of activities and programs effectively prevent substance use among youth.

Two large, well-known studies demonstrate the positive impacts of treatment. According to one,[37] substance abuse treatment programs are remarkably cost-effective: every $1 spent on treatment saves the public up to $7. This study found that treatment had an impact on costs by reducing crime and the burden of providing care for avoidable illness and injury. The level of crime was found to decline by two thirds following treatment. Emergency room admissions and hospitalizations were reduced by one third. The benefits of treatment were found to outweigh the costs by ratios that ranged from 4:1 to 12:1, depending on the type of treatment. Research results have continued to demonstrate that substance abuse treatment works, reduces costs, and improves lives, allowing individuals to be more productive, independent and self-sufficient.

The second study[38] assessed the impact of drug and alcohol treatment over a five-year period on 5,388 clients treated in public substance abuse treatment programs. Comparisons were made between the year prior to treatment and the year following to determine the impact of treatment in a variety of areas including alcohol and drug use, criminal behaviors, employment, housing, and physical and mental health. Results demonstrated significant improvement in relapse rates, economic status, and physical and mental health, as well as significant decreases in criminal behavior.

In Vermont, the value of treatment and prevention services has been shown by efforts such as the New Directions Project, which demonstrated statistically significant decreases in youth substance use in areas receiving project services. In the past several years, there also is more evidence for the value of particular practices and programs. Training, education and skill development for substance abuse professionals should be informed by, and focused on, this evidence.

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of Human Services, Performance Measurement & Quality Improvement, Health Care Research and Evaluation Division.

[37] Gerstein, D.R.; Johnson, R.A.; Harwood, H.J.; Fountain, D.; Suter, N.; Malloy, K. Evaluating recovery services: The California Drug and Alcohol Treatment Assessment (CALDATA). General Report and Executive Summary. Sacramento, CA: State of California, Health and Welfare Agency, 1994. 95 p. (124575)

[38] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, The National Treatment Improvement Evaluation Study. Washington, D.C.: (February, 1997). Hhttp://www.samhsa.gov/centers/csat/csat.htmlH

In addition to assuring that professionals are trained to deliver state-of-the art services, the delivery of drug and alcohol treatment and prevention services must be monitored, evaluated and reported to the public in order to assure the highest performance and cost effectiveness possible. The federal Substance Abuse and Mental Health Services Administration now requires performance measurement reporting on funds provided to states. Collaborations are underway between the Department of Health and treatment service providers to improve accountability at the community level.